		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038760

Facility Name: FLORA PAVILION NURSING HOME CTR

Address: 701 SHADWELL (Number) FLORA (City) 62839 (Zip Code)

County: CLAY

Telephone Number: (847) 674-4700 **Fax #** (847) 674-4733

IDPA ID Number: 37-1304216

Date of Initial License for Current Owners: 02/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DON FIETS **Telephone Number:** (847) 674-4700 X40

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) BRADLEY ALTER
(Title) VICE PRESIDENT

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	56	Skilled (SNF)	56	20,496	1
2		Skilled Pediatric (SNF/PED)			2
3	54	Intermediate (ICF)	54	19,764	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,260	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,475	3,475	8
9	SNF/PED					9
10	ICF	16,445	3,938	444	20,827	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,445	3,938	3,919	24,302	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.36%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 3,475

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	124,572	8,010	7,901	140,483		140,483		140,483			1
2	Food Purchase		106,857		106,857		106,857	(331)	106,526			2
3	Housekeeping	83,911	19,546		103,457		103,457	75	103,532			3
4	Laundry	34,260	11,651	886	46,797		46,797		46,797			4
5	Heat and Other Utilities			53,519	53,519		53,519		53,519			5
6	Maintenance	30,554	23,521	13,068	67,143		67,143	42	67,185			6
7	Other (specify):*			15,133	15,133		15,133		15,133			7
8	**TOTAL General Services**	273,297	169,585	90,507	533,389		533,389	(214)	533,175			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	842,443	52,384	33,703	928,530		928,530	12,721	941,251			10
10a	Therapy	86,133	3,665	166	89,964		89,964		89,964			10a
11	Activities	56,040	2,369	153	58,562		58,562		58,562			11
12	Social Services	43,804		2,272	46,076		46,076		46,076			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,028,420	58,418	42,294	1,129,132		1,129,132	12,721	1,141,853			16
	C. General Administration											
17	Administrative	36,867		12,000	48,867		48,867	22,746	71,613			17
18	Directors Fees											18
19	Professional Services			93,749	93,749		93,749	(30,335)	63,414			19
20	Dues, Fees, Subscriptions & Promotions			13,740	13,740		13,740	(6,431)	7,309			20
21	Clerical & General Office Expenses	47,133	10,959	123,648	181,740		181,740	(25,826)	155,914			21
22	Employee Benefits & Payroll Taxes			268,844	268,844		268,844	16,730	285,574			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,746	2,746		2,746	6,294	9,040			24
25	Other Admin. Staff Transportation			4,815	4,815		4,815	8,027	12,842			25
26	Insurance-Prop.Liab.Malpractice			74,700	74,700		74,700	2,307	77,007			26
27	Other (specify):*											27
28	**TOTAL General Administration**	84,000	10,959	594,242	689,201		689,201	(6,488)	682,713			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,385,717	238,962	727,043	2,351,722		2,351,722	6,019	2,357,741			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: FLORA PAVILION NURSING HOME CTR #0038760 **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,901	
	REPAIRS & MAINTENANCE		0	
			0	7,901
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		886	
			0	886
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		17,266	
	ELECTRICITY		27,803	
	WATER		8,450	
	CABLE TV - LOBBY		0	
			0	53,519
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,110	
	PAINTING & DECORATING		496	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		7,399	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		960	
	FIRE SERVICE		1,103	
			0	
			0	
			0	13,068
7	**OTHER**			
	SCAVENGER		15,133	
	SECURITY SERVICE		0	15,133
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	32,373	
	LABORATORY & XRAY EXPENSE		215	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	990	
	PHARMACY CONSULTANT	XVIII B 39-2	125	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	33,703
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	14	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	152	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	166
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	153	
			0	153
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,272	
			0	2,272
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR **#0038760** **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	12,000	12,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	6,036	
	ADMINISTRATIVE CONSULTANTS	XIX C	32,400	
	PROFESSIONAL FEES	XIX C	55,313	
			0	93,749
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	4,335	
	EMPLOYEE WANT ADS	XIX F	5,416	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	297	
	LICENSES & PERMITS	XIX F	1,568	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	2,124	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	13,740
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		556	
	OUTSIDE CLERICAL SERVICES		104,865	
	PENALTIES / OVERDRAFT CHARGES	VI 18	4,104	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		67	
	TELEPHONE		11,499	
	MESSENGER SERVICE		2,557	
			0	123,648

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	104,115	
	UNEMPLOYMENT COMPENSATION	XIX D	29,030	
	WORKERS COMPENSATION INSURANCI	XIX D	59,254	
	HOSPITALIZATION INSURANCE	XIX D	72,283	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,131	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	2,031	
	CHICAGO HEAD TAX	XIX D	0	268,844
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	566	
	TRAVEL	XIX G	2,180	
			0	
			0	2,746
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		4,815	4,815
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		74,700	74,700
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 727,043

FLORA PAVILION NURSING HOME CTR
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	106,857	PATIENT MEALS	72906
LESS SALES TAX	(331)	ADD EMPLOYEE MEALS	0
NET FOOD	106,526	TOTAL MEALS/YEAR	72906
TOTAL PATIENT CENSUS	24,302	NET FOOD	106526
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	72906
TOTAL PATIENT MEALS	72906	COST PER MEAL	1.46
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR #0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			21,463	21,463		21,463	134,316	155,779			30
31	Amortization of Pre-Op. & Org.							8,413	8,413			31
32	Interest			27,108	27,108		27,108	119,489	146,597			32
33	Real Estate Taxes			34,904	34,904		34,904		34,904			33
34	Rent-Facility & Grounds			194,227	194,227		194,227	(189,421)	4,806			34
35	Rent-Equipment & Vehicles			5,271	5,271		5,271	359	5,630			35
36	Other (specify):* storage			1,020	1,020		1,020		1,020			36
37	**TOTAL Ownership**			283,993	283,993		283,993	73,156	357,149			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		71,085	101,697	172,782		172,782		172,782			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,390	60,390		60,390		60,390			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		71,085	162,087	233,172		233,172		233,172			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,385,717	310,047	1,173,123	2,868,887		2,868,887	79,175	2,948,062			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,774	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(331)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(4,104)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(4,335)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,124)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,120)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	80,295		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 80,295		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 79,175		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

FLORA PAVILION NURSING HOME CTR

ID# 0038760

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(331)	0	0	0	0	0	0	0	0	0	0	(331)	2
3	Housekeeping	0	0	75	0	0	0	0	0	0	0	0	75	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	42	0	0	0	0	0	0	0	0	42	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(331)	0	117	0	0	0	0	0	0	0	0	(214)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	12,721	0	0	0	0	0	0	0	0	12,721	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	12,721	0	0	0	0	0	0	0	0	12,721	16
	C. General Administration													
17	Administrative	0	(12,000)	34,746	0	0	0	0	0	0	0	0	22,746	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(32,400)	2,065	0	0	0	0	0	0	0	0	(30,335)	19
20	Fees, Subscriptions & Promotions	(6,459)	0	28	0	0	0	0	0	0	0	0	(6,431)	20
21	Clerical & General Office Expenses	(4,104)	(101,505)	79,783	0	0	0	0	0	0	0	0	(25,826)	21
22	Employee Benefits & Payroll Taxes	0	0	16,730	0	0	0	0	0	0	0	0	16,730	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	6,294	0	0	0	0	0	0	0	0	6,294	24
25	Other Admin. Staff Transportation	0	0	8,027	0	0	0	0	0	0	0	0	8,027	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,307	0	0	0	0	0	0	0	0	2,307	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(10,563)	(145,905)	149,980	0	0	0	0	0	0	0	0	(6,488)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(10,894)	(145,905)	162,818	0	0	0	0	0	0	0	0	6,019	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	9,774	122,725	1,817	0	0	0	0	0	0	0	0	134,316	30
31	Amortization of Pre-Op. & Org.	0	8,413	0	0	0	0	0	0	0	0	0	8,413	31
32	Interest	0	119,489	0	0	0	0	0	0	0	0	0	119,489	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(194,227)	4,806	0	0	0	0	0	0	0	0	(189,421)	34
35	Rent-Equipment & Vehicles	0	0	359	0	0	0	0	0	0	0	0	359	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	9,774	56,400	6,982	0	0	0	0	0	0	0	0	73,156	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,120)	(89,505)	169,800	0	0	0	0	0	0	0	0	79,175	45

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		CERTIFIED HEALTI	SKOKIE	BKKPG/MGMT
				MGMT		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 12,000	CERTIFIED HEALTH MGMT		$	$ (12,000)	1
2	V	21	BOOKKEEPING	104,865				(104,865)	2
3	V	19	ADMIN CONSULTING FEES	32,400				(32,400)	3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	194,227				(194,227)	7
8	V	21	OFFICE EXPENSE				3,360	3,360	8
9	V	30	DEPRECIATION				122,725	122,725	9
10	V	31	AMORTIZATION				8,413	8,413	10
11	V	32	INTEREST				119,489	119,489	11
12	V								12
13	V								13
14	Total			$ 343,492			$ 253,987	$ * (89,505)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	CERTIFIED HEALTH MANAGEMENT		$ 75	$ 75	15
16	V	5	ELECTRIC & GAS		" " "		0		16
17	V	6	MAINTENANCE		" " "		42	42	17
18	V	10	NURSING/MEDICAL RECORDS		" " "		12,721	12,721	18
19	V	17	ADMIN SALARIES		" " "		34,746	34,746	19
20	V	19	PROFESSIONAL FEES		" " "		2,065	2,065	20
21	V	20	FEE, SUBSCRIPTIONS		" " "		28	28	21
22	V	21	OFFICE EXP.		" " "		79,783	79,783	22
23	V	22	EMPLOYEE BENEFITS		" " "		16,730	16,730	23
24	V	24	TRAVEL/SEMINAR		" " "		6,294	6,294	24
25	V	25	TRANSPORTATION		" " "		8,027	8,027	25
26	V	26	INSURANCE		" " "		2,307	2,307	26
27	V	30	DEPRECIATION		" " "		1,817	1,817	27
28	V	32	INTEREST		" " "		0		28
29	V	34	OFFICE RENT		" " "		4,806	4,806	29
30	V	35	EQUIPMENT RENTAL		" " "		359	359	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 169,800	$ * 169,800	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FLORA PAVILION NURSING HOME CTI # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	BRADLEY ALTER		ADMINISTRATION		SEE ATTACHED SCHEDULE			SALARY	$ 10,270	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 10,270		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CERTIFIED HEALTH MANAGEMENT
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-4700
Fax Number: (847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	244,189	8	$ 750	$	24,302	$ 75	1
2	5	ELECTRIC & GAS	" " "	244,189	8	0		24,302	0	2
3	6	MAINTENANCE	" " "	244,189	8	420		24,302	42	3
4	10	NURSING/MEDICAL RECORDS	" " "	244,189	8	127,817	127,817	24,302	12,721	4
5	17	ADMIN SALARIES	" " "	244,189	8	349,136	349,136	24,302	34,746	5
6	19	PROFESSIONAL FEES	" " "	244,189	8	20,751		24,302	2,065	6
7	20	FEE, SUBSCRIPTIONS	" " "	244,189	8	285		24,302	28	7
8	21	OFFICE EXP.	" " "	244,189	8	801,665	683,000	24,302	79,783	8
9	22	EMPLOYEE BENEFITS	" " "	244,189	8	168,109		24,302	16,730	9
10	24	TRAVEL/SEMINAR	" " "	244,189	8	63,242		24,302	6,294	10
11	25	TRANSPORTATION	" " "	244,189	8	80,653		24,302	8,027	11
12	26	INSURANCE	" " "	244,189	8	23,179		24,302	2,307	12
13	30	DEPRECIATION	" " "	244,189	8	18,257		24,302	1,817	13
14	32	INTEREST	" " "	244,189	8	0		24,302	0	14
15	34	OFFICE RENT	" " "	244,189	8	48,291		24,302	4,806	15
16	35	EQUIPMENT RENTAL	" " "	244,189	8	3,606		24,302	359	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,706,161	$ 1,159,953		$ 169,800	25

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FLORA PAVILION NURSING HOME LLC
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-4700
Fax Number: (847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT COSTS	1	1	$ 122,725	$	1	$ 122,725	1
2	31	AMORTIZATION		1	1	8,413		1	8,413	2
3	32	INTEREST		1	1	119,489		1	119,489	3
4	21	OFFICE EXP		1	1	3,360		1	3,360	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 253,987	$		$ 253,987	25

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	BANK FINANCIAL		X	MORTGAGE	$8,713.00	05/03	$	$ 1,222,901	05/09	PRIME+	$ 84,451	1
2	GERSON BASSMAN	X		MORTGAGE				884,768		8.9000	25,194	2
3	BANK FINANCIAL		X	MORTGAGE	$4,261.00		715,867	159,217		PRIME+	9,844	3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL		X	WORKING CAPITAL				409,606		PRIME+	17,757	6
7	OFFICERS	X		WORKING CAPITAL				479,969			7,032	7
8	INSRUANCE FINANCING		X	INS FINANCING							2,319	8
9	TOTAL Facility Related				$12,974.00		$ 715,867	$ 3,156,461			$ 146,597	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 715,867	$ 3,156,461			$ 146,597	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 37,640	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 35,914	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,726)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 36,630	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 34,904	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999	48,634	8
2000	52,608	9
2001	53,717	10
2002	37,640	11
2003	35,914	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FLORA PAVILION NURSING HOME CTR COUNTY CLAY

FACILITY IDPH LICENSE NUMBER 0038760

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-25-200-005	NURSING HOME	$ 35,914.12	$ 35,914.12
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 35,914.12	$ 35,914.12

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 165,000	1
2					2
3	TOTALS			$ 165,000	3

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	110		2000		$ 2,970,000	$ 108,000	27.5	$ 108,000	$	$ 508,507	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FANS			1993	1,891	48	39	48	0	554	9
10	ROOF			1993	15,000	386	39	385	(1)	4,412	10
11	DRIVEWAY			1993	16,855	432	39	432	0	4,842	11
12	STRIP PARKING LOT			1993	280	7	39	7	0	76	12
13	AWNING			1993	948	24	39	24	0	268	13
14	FROOF			1994	1,909	49	39	49	(0)	500	14
15	FRONT ENTRY REPAIR			1996	4,236	109	39	109	(0)	958	15
16	DUCT MODIFICATION			1996	11,970	307	39	307	(0)	2,571	16
17	CONCRETE WORK			1996	5,510	367	15	367	0	3,124	17
18	CONSULT REROOFING			1997	540	14	39	14	(0)	107	18
19	DOOR ALARM SYSTEM			1997	700	18	39	18	(0)	130	19
20	REPLACE ROOF			1997	14,760	378	39	378	0	2,662	20
21	ROOF TOP AC			1998	10,372	266	39	266	(0)	1,696	21
22	ROLLLING DOOR			1998	2,962	76	39	76	(0)	472	22
23	CARPET			1998	3,160	81	39	81	0	503	23
24	ROOF REPAIR			1999	16,688	428	39	428	(0)	2,553	24
25	PAINTING/FLOORING			1999	19,553	501	39	501	0	2,949	25
26	SEWER LINE/PUMP/SOIL TESTING			1999	3,537	91	39	91	(0)	497	26
27	HOT WATER HEATER			2000	4,579	654	7	654	0	2,304	27
28	ROOF REPAIR			2000	21,518	782	27.5	782	0	3,284	28
29	WASH/PAINT BUILDING			2000	4,820	175	27.5	175	0	795	29
30	BATHROOM REMODEL			2000	10,925	398	27.5	397	(1)	1,605	30
31	AC RETURN			2000	1,000	36	27.5	36	0	158	31
32	ROOF REPAIR			2001	25,160	915	27.5	915	(0)	3,317	32
33				2001	3,062	111	27.5	111	0	393	33
34	FIRE SUPPRESSION SYSTEM			2002	1,893	69	27.5	69	(0)	163	34
35	WALLCOVERINGS DINING ROOM			2003	2,562	820	5	512	(308)	1,024	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BREAKER REPLACEMENT	2004	$ 1,700	$ 24	27.5	$ 31	$ 7	$ 31	37
38	DOOR ALARM SYSTEM	2004	2,405	44	27.5	44	(0)	44	38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,180,495	$ 115,610		$ 115,309	$ (301)	$ 550,501	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 158,617	$ 11,282	$ 23,499	$ 12,217	5-7 YRS	$ 67,120	71
72	Current Year Purchases	4,285	2,571	429	(2,143)	5	429	72
73	Fully Depreciated Assets	29,211					29,211	73
74			16,542	16,542				74
75	TOTALS	$ 192,113	$ 30,395	$ 40,469	$ 10,074		$ 96,759	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,537,608	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 146,005	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 155,779	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,774	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 647,261	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 5,271 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 26,715	$		$ 26,715	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			18,044			18,044	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			56,938			56,938	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				30,930		30,930	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): med supply/lab	39-2					40,155		40,155	13
14	TOTAL			$		$ 101,697	$ 71,085		$ 172,782	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,043)	449,151		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,723		6
7	Other Prepaid Expenses	2,944		7
8	Accounts Receivable (owners or related parties)	4,760		8
9	Other(specify): R/E TAX ESCROW	22,408		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 501,986	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	210,496		15
16	Equipment, at Historical Cost	192,113		16
17	Accumulated Depreciation (book methods)	(220,016)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 182,593	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 684,579	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 317,094	$	26
27	Officer's Accounts Payable	479,969		27
28	Accounts Payable-Patient Deposits	1,000		28
29	Short-Term Notes Payable	1,270,438		29
30	Accrued Salaries Payable	10,909		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,806		31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,630		32
33	Accrued Interest Payable	12,212		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,133,058	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,133,058	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,448,479)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 684,579	$	48

*(See instructions.)

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,424,378)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,424,378)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(24,101)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (24,101)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,448,479)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,569,221	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,569,221	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	257,677	6
7	Oxygen	17,878	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 275,555	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,844,786	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	533,389	31
32	Health Care	1,129,132	32
33	General Administration	689,201	33
	B. Capital Expense		
34	Ownership	283,993	34
	C. Ancillary Expense		
35	Special Cost Centers	172,782	35
36	Provider Participation Fee	60,390	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,868,887	40
41	**Income before Income Taxes (line 30 minus line 40)****	(24,101)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (24,101)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,952	2,080	$ 47,915	$ 23.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,858	10,502	209,594	19.96	3
4	Licensed Practical Nurses	4,820	5,171	78,310	15.14	4
5	Nurse Aides & Orderlies	41,052	44,153	428,263	9.70	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,521	3,994	86,133	21.57	8
9	Activity Director	2,048	2,232	31,515	14.12	9
10	Activity Assistants	2,945	3,266	24,525	7.51	10
11	Social Service Workers	2,790	2,862	43,804	15.31	11
12	Dietician					12
13	Food Service Supervisor	1,992	2,080	23,583	11.34	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,082	3,303	30,841	9.34	15
16	Dishwashers	7,687	7,924	70,148	8.85	16
17	Maintenance Workers	2,043	2,291	30,554	13.34	17
18	Housekeepers	10,847	11,173	83,911	7.51	18
19	Laundry	4,632	4,926	34,260	6.95	19
20	Administrator	750	750	17,806	23.74	20
21	Assistant Administrator	1,012	1,012	19,061	18.83	21
22	Other Administrative					22
23	Office Manager	1,865	2,070	27,322	13.20	23
24	Clerical	1,870	2,078	19,811	9.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,127	2,349	38,508	16.39	31
32	Other Health C: CARE PLAN COO	1,984	2,080	39,853	19.16	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	108,877	116,296	$ 1,385,717 *	$ 11.92	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	200	$ 7,901	1-3	35
36	Medical Director	500/month	6,000	9-3	36
37	Medical Records Consultant	30	990	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	5	125	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		14	10a-3	41
42	Respiratory Therapy Consultant		152	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		153	11-3	44
45	Social Service Consultant	54	2,272	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	289	$ 17,607		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	505	$ 20,691	10-3	50
51	Licensed Practical Nurses	365	11,682	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)	870	$ 32,373		53

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SHARON MATHIS	ADMIN		$ 17,806
AMY BORING	ASST ADMIN		19,061
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 36,867

B. Administrative - Other

Description	Amount
CERTIFIED HEALTH MGMT	$ 12,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 12,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		93,749
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 93,749

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 59,254
Unemployment Compensation Insurance		29,030
FICA Taxes		104,115
Employee Health Insurance		72,283
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		2,131
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		2,031
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
MGMT CO ALLOCATION		16,730
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 285,574

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
NONE		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,416
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	6,459
TRUST/FRANCHISE/CONTRIB/ETC	0
LICENSES & PERMITS	1,568
DUES & SUBSCRIPTIONS	297
MGMT CO ALLOCATION	28
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(4,335)
Yellow page advertising	(2,124)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,309

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	2,180
Seminar Expense	
	566
MGMT CO ALLOCATION	6,294
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,040

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number FLORA PAVILION NURSING HOME CTR # 0038760 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **60,390**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees